THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-04-8342.M5

MDR Tracking Number: M5-04-2168-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 16, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit, needle electromyography (95861), nerve conduction (95900), no F Wave (95904), sensory nerve conduction test, each nerve, H or F reflex study (95935/95935-50) were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for date of service 07-03-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 13th day of June 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 7, 2004

MDR Tracking #: M5-04-2168-01 AMENDED DECISION
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic reviewer who is board certified and has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
The claimant has a history of chronic back pain allegedly related to a compensable injury on ___.

Requested Service(s)
Office visit,Needle electromyography (95861), nerve conduction (95900), no F Wave (95904), sensory nerve conduction test, each nerve, H or F reflex study (95935/95935-50).

Decision
I agree with the insurance carrier that the requested office visit and electrodiagnostic studies are not medically necessary.

Rationale/Basis for Decision
The claimant was initially treated for a contusion of the right hip at ___ in ___ on ___. Plain radiographs of the hip and lumbar spine taken at that time were reportedly normal. An MRI report of the lumbar spine dated March 20, 2002 was normal. A NCV study report dated April 11, 2002 indicated non-specific F wave abnormalities suggestive of right L5 nerve irritation. An evaluation by ___of the ___ performed on 6/18/02 concludes with a clinical impression of "right lateral pelvic pain, etiology uncertain secondary to strain syndrome with marked Waddel's signs. Rule out central pain magnification." The claimant reached maximum medical improvement on 6/20/02 with a 5% impairment rating. Generally, a repeat EMG/NCV study is indicated in the presence of acute neurologic change or progressive neurologic deficit. There is no documentation of acute change or progressive neurologic deficit to indicate the medical necessity of a repeat NCV study 16 months after the alleged work compensable event. The claimant exhibits a chronic pain syndrome with inconsistent poorly localized neurologic symptoms. No further diagnostic intervention is deemed to be medically necessary.